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AUTHOR Matthews, Barbara
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ABSTRACT

A therapeutic play program in New Zealand aims to provide an environment that helps children cope with the stress of being in a hospital. A relatively new aspect of child health care in New Zealand, the therapeutic play program is a preventive mental health program that differs from play therapy, which is intervention for children who have an identified pathology. The therapeutic play program model transforms the potentially psychologically harmful hospital experience into a challenging experience through which the child can learn and grow. The program has the following aims: (1) to meet a child's ongoing developmental needs; (2) to help children cope with the unfamiliar hospital environment; (3) to increase children's understanding of their hospitalization and treatment; (4) to promote a sense of control, mastery, and positive self-concept; (5) to facilitate self-expression; and (6) to meet a child's need to cope with separation and deprivation. Examples of the translation of these aims into play activities are given. Contains 16 references. (LB)

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A THERAPEUTIC PLAY PROGRAMME FOR YOUNG HOSPITALISED CHILDREN

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Barbara Matthews
Hospital Play Specialist
Director Play and Recreation Department
Auckland Children's Hospital

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Introduction

The importance of play in the healthy development of children is well recognised. Hospitalisation is a time of stress for young children disorganising, interrupting and inhibiting the child's ability to play, (Burstein and Meichenbraum, 1979, Tisca, Hurwitz and Angoff, 1970 cited in Thompson, 1986) depriving the child of one of their most important coping mechanisms. A therapeutic hospital play programme aims to provide an environment that enables the child to engage their ability to play to help them cope with the stress of being in hospital1. The aims of a Therapeutic Play Programme are outlined. The way that these aims are translated into play activities will be considered and supported by examples. In conclusion the theoretical framework on which the programme is based will be summarised.

Therapeutic Play Programmes (TPP) are a relatively new aspect of child health care and special education in New Zealand. A 1979 study by Robin McKinlay showed that provision of hospital play programmes lagged behind that of other countries and did not reflect the growing recognition overseas of the value of supervised play in hospitals. A later study by the Health and Education Departments (1987) showed little improvement. McKinlay's study of New Zealand hospitals (1983) identified three different models of play - three different ways that play is viewed within hospitals. Play, in the first model, is viewed merely as a distraction from the hospital experience. The aim of such a programme is to keep children happy. The Hospital Play Specialist's (HPS) role is largely that of "mother" substitute. The second model, the educational model, assumes that play is an essential tool for children's development without which hospitalised children are deprived of necessary conditions for normal life. Staff have professional training but they are outside the team of healthcare givers. The third model, the therapeutic model, encompasses both the other two models but adds the further dimension of play as psychotherapy. In this model play mediates between the child and their hospital experience aiming to transform the potentially psychologically harmful experience to a challenging experience through which the child can learn and grow. The HPS is included as part of the healthcare team caring for the child. The TPP is therefore a preventive mental health programme and differs therefore from Play Therapy which is intervention for children who have some identified pathology.

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1 "In Hospital" is defined as inpatients,day-stay patients, children seen but not admitted, outpatients and siblings.

Research indicates that children, of their own accord, may use play to help cope with the stresses accompanying health care (Gilmore, 1966, cited in Gaynard, Wolfer, Goldberger, Thompson, Redburn and Liadley, 1990). Few studies however have examined the effectiveness of play interventions in hospital. Those that do provide encouraging results. In 1970 Lockwood (cited in Gaynard et al, 1990) found that children engaged in a single medical play session on admission had significantly lower anxiety-defence scores after the session. A study by Clatworthy (1981) of 114 5 to 12 years old children admitted to a paediatric hospital over a four year period showed that anxiety levels of children who did not receive therapeutic play increased during their hospitalisation, whereas there was no significant increase in the measured anxiety levels of those children who did receive daily 30 minute sessions of therapeutic play. Using a similar design Peterson and Shigetomi (1981, cited in Gaynard et al 1990) observed the affect and interaction of 2 - 17 year olds during a 20 minute play intervention. Increase in both positive affect and interaction were observed. However the changes observed returned to baseline in the post intervention period suggesting that it was the presence of the HPS that facilitated the play and changes in affect. Finaly, Schartz, Albino and Tedesco (1983, cited in Thompson 1986) found that nondirective play in the presence of an adult may be helpful in modifying children's upset during hospitalisation, even when the play is unrelated to hospital experience.

Aims of a Therapeutic Play Programme

The aims of a TPP (Matthews, 1987) are:-

1) to meet the ongoing developmental needs of individual children.
2) to assist children in coping with the unfamiliarity of the hospital environment.
3) to increase children's understanding of their hospitalisation and treatment
4) to promote a sense of control, mastery, and positive self concept; to allow children to make some impact on their environment.
5) to facilitate children's self expression: sharing of feelings, concerns and their understanding of illness, treatment and the role of hospital staff.
6) to meet the child's need to cope with separation and deprivation (and/or over stimulation).

These aims are not listed in order of priority. The importance of each of these aims will depend on the needs of the individual child in terms of their age, personality, level of family support, extent to which the child is emotionally secure, level of understanding and coping mechanism, previous experience of hospital and illness, the severity of the illness and the nature of the treatment required and the degree to which anxiety about the child's condition is communicated to the child. In implementing these aims the cultural background of the child must be considered.

Meeting the ongoing developmental needs of the child.

A play programme that meets the ongoing developmental meeds of the child in hospital resembles any early childhood programme with some subtle differences. The play of hospitalised children is inhibited because of the child's ill health and the hospital environment. To stimulate play hospitalised children need to have an adult to facilitate play, toys to play with and an environment in which the child feels safe to play. A safe playroom in this sense is one where no treatment will be carried out. Children in hospital regress causing feelings of confusion and become frustrated because they are unable to complete tasks that normally they can achieve. Strong emphasis is therefore placed on activities such as play dough, art activities and water play; activities where the child can vary their level of functioning. The experience of being hospitalised bombards children with unfamiliar experiences and new stimuli much of which the child is attempting to assimilate. A TPP therefore does not include planned teaching sessions on for instance colours or mathematical sets. Learning and maintenance of these of these skills can be achieved through incidental learning (eg "You have made a pig with the yellow cutter").

Assisting Children to Cope With the Unfamiliar Hospital Environment.

To assist children to cope with the unfamiliarity of the hospital environment the HPS may encourage the child to explore the immediate environment while riding a bike. Playing a board game about hospitals encourages children to discriminate between different aspects of the hospital experience rather than seeing and dealing with it as an entire experience. When landing on the square they have called "Nil Per Mouth" results in their counter again going back to the beginning of the game children often reassess just how bad not being able to eat was, for instance, in comparison with having an IV inserted. Reading books about hospital, playing hospital games and exploration of the environment stimulate discussion about the things children have seen and heard.

> *"That baby is crying because the doctor wants to hurt her."*

or

> *"That boy* (in traction) *is being tied down."*

Medical play helps children of all ages, 12 months through to and including adolescence, to become familiar with unknown aspects of their care and to learn new coping strategies. Medical play is defined by McCue (1988) as a form of play that always has as part of its content medical themes and/or the use of medical equipment. Medical play like any other play is freely chosen by the child. However it does differ from other dramatic play in that it may not always appear to be enjoyable. Children involved in medical play may become intense and aggressive. The role of adults may be passive with the play being child directed or the adult may become actively involved participating in the play perhaps suggesting an alternative scenario.

> *"Dolly has to wriggle and wriggle when she has a needle.... You and I could teach dolly something different to do when she has her needle."*

McCue (1988) identifies four different types of medical play; role reversal/role rehearsal medical play, medical fantasy play, indirect medical play and medical art. The most traditional type of medical play is role reversal/role rehearsal play which allows children to take on the roles of health care professional re-enacting the procedures that they have experienced on models such as their hospital doll. The child becomes actively involved, manipulating and exploring the medical equipment clarifying the purpose of the equipment

> "*the thermometer is to measure how warm you are dolly*".

Children with the most understanding of medical equipment have been shown to be the least anxious about medically related situations (Siaw, Stephens, Holmes, 1986). Medical fantasy play does not include specific medical equipment. Rather it involves play of themes associated indirectly with hospitalisation. HPS may be locked in jail, the crashed cars may get badly hurt. Children engaging in this form of play may progress to using medical equipment in role reversal play as they become less anxious. Indirect medical play includes play using medical equipment for other purposes (such as using syringes for dough and water play) and play using puzzles and games about hospitals or related themes (such as food, separation or home role themes). Indirect medical play can be useful for the very fearful, noncommunicative child and the very sick child. Medical art includes any artwork (painting, collage, box construction etc) and gives the children the opportunity to express their understanding of and psychosocial reaction to their medical experiences. Art requires little physical energy which enhances its usefulness as a therapeutic communication with hospitalised children (Clatworthy, 1981).

> *Debbie aged ten was having some difficulty coping with the permanence of her diabetes. She drew diabetes surrounded by two hands. The hands represented death and dying and were to squish the diabetes. Debbie knew that the only way to get rid of the diabetes was for her to die. She didn't want to die and she didn't want to live with diabetes.*

Medical play is freely available in the playroom with a hospital corner set up alongside the family play area. Medical play is also offered to children in their bedrooms. Care must be made by the HPS to provide a balance between medical play and other age appropriate play activities.

Children can be encouraged to learn more mature coping strategies using medical play in conjunction with other techniques. A play programme was devised for five year old, Betty, who needed five people to hold her down for her weekly blood tests, to help her overcome her fear of the needles.

> *The HPS wrote a story about a little girl, Jenny, of the same age who was very scared of dogs. The story told of Jenny's successful efforts to make her fears smaller and smaller and to take control of her fears. Betty illustrated the book. The activities in the book that helped Jenny overcome her fears were discussed and suitable activities offered to Betty. Betty made a collage picture using syringes and cotton wool* (medical art), *mixed colours using syringes* (indirect medical play) *and was engaged in needle play with her hospital doll* (role reversal medical play). *Betty was encouraged to draw her fears and then draw those fears smaller and smaller. She was then taught visualisation as a coping technique to help her lie still while the blood test was carried out.*

At the completion of the programme Betty was able to hold out her arm for her blood tests. The first week she needed somebody to hold her arm to help keep it still but after that she was able to do it by herself. The pride and feelings of mastery this child experienced were very apparent.

Increasing children's understanding of their hospitalisation and treatment.

Medical play is also an important technique for increasing children's understanding of the reason for their hospitalisation and treatment. Observing a child at medical play gives insight to the child's understanding. A three year old described leukaemia *"as teddy having jelly beans up his nose"* (he had been looking at the pictures of blood cells), the four year old described diabetes *"as a spider in the tummy of her hospital doll"*. In the absence of an age appropriate explanation children draw on their previous knowledge to create an explanation for their hospitalisation, illness and treatment. Often the explanation they create is more scary than the real one.

> *Kate, a very active eight year old, knew that the type of leukaemia she had was the more severe of the two types. "This doll," she said, "has the hyperactive leukaemia; this one doesn't. The doll without the hyperactive leukaemia is going to be made better by the doctors. The one with the hyperactive leukaemia is waiting for the doctors to decide when she will die.*

Using repeated sessions of medical play children show evidence of more mature cognitive processing. Three year old Susan used small world play to clarify her understanding of the role of hospital staff after her admission to hospital with severe asthma.

> *Initially the nurse doll was the angry person chasing the children frightening them. The mummy and daddy were lost. After several sessions the angry nurse became the naughty nurse helping the children to find their parents.*

Susan was then able to move from a three year old's concept of the role of health professionals (that people that hurt you do it because you are naughty and they are angry with you) to a more mature concept. She now was beginning to understand that things or people that hurt you can also help you.

Special play preparation programmes have been developed to help children to understand anticipated procedure such as blood tests, temperature taking, surgical procedures (from grommets to amputations) and treatments (eg radiotherapy). Parents, and where possible, siblings are involved in the preparation. Information given must be accurate and be at the level appropriate to the child's psycho-social development, emphasising the sensations and feelings the child will feel (the prick will hurt, the wipe is cold and stinky, the anaesthetic makes you feel twirly and dizzy in the head). Individual hospital rag dolls are given to all children and are used as models for preparation sessions. A medical play session precedes the preparation giving the HPS an indication of the child's understanding of and feelings about the anticipated procedure. The HPS then plays through the procedure actively involving the child. The "game" is repeated adding more information each time as appropriate to the child's age. Throughout

the game resistance or avoidance by the child (or the doll) can be used to generate active listening statements ("Dolly feels very scared") or feeling of control in the child ("Dolly says go away, go away!!"). Appropriate coping strategies can be explored. Preparation programmes for older children increasingly rely on discussion, body outlines and visual aids such as the Zaadi dolls. Preparation is an integrated part of an child's individual programme. The effectiveness of such programmes is probably best illustrated by the response of children being prepared for radiotherapy. With the play programme children having radiotherapy for treatment of leukaemia and aged three years and over are able to lie in the room on their own with their head held still by a plastic face mask clamped to the table.

After the procedure/treatment children are encouraged to have play through the procedure again. Postprocedural medical play sessions are particularly valuable for children who were not able to be prepared for the procedure.

> *Six year old Tamati, following his emergency surgery, spent nine consecutive sessions playing through what had happened. Initially he directed the HPS's play but with each subsequent session Tamati became increasingly involved adding a little more of his understanding to his hospital game.*

Promoting sense of control, mastery and positive self-concept and allowing children to make some impact on their environment.

A sense of mastery and control are associated with a positive hospital experience (Beuf, 1979). A TPP therefore encourages games involving self awareness such as "peek-a-boo" and "round and round the tennis court", dressing up or face painting. Older children write messages about themselves and their family or makes rules such as "No boys allowed in this room". Materials that allow the child the greatest choice and the least opportunity for error (sand, water, playdough) and activities that maximize the opportunity for creative and constructive play (painting, blocks) are important in the hospital environment in which children are required to give up so much of their control. The escaping into the world of their imagination helps children cope with the experience of being in hospital.

> *To help cope with her blood tests Betty imagined she was riding a brand new pink bike around her neighbourhood.*

Facilitating Children's Self Expression: Sharing of Feelings, Concerns and their Understanding of Illness, Treatment and the Role of Hospital Staff

Children who can express their concerns and fears are more likely to feel the sense of mastery and control that enable effective information processing and the lowering of uncertainty about hospital procedures and treatment. Much of the emphasis of a TPP is therefore on encouraging children's self expression. Small world play is often stimulated with a sand tray and small figures and animals or with the hospital playmobile sets.

Four year Jason came to the hospital crying "Don't kill me, don't kill me". Recently his Grandfather had died in hospital. Initially in his play everybody in the ambulance died in hospital. Gradually less and less people died until finally he was able to share with the HPS how he missed his grandfather and how angry he was that he had left him.

Puppets are chosen by some children to share their concerns.

Four year old Max had been unable to eat without choking. Sometimes he even stopped breathing. After his surgery Max used a frog puppet to work though his fears about eating and dying, directing the HPS to make the puppet choke on the play dough. He would resuscitate the frog and then feed him some more playdough.

Many children chose to use art as a way of expressing their feelings.

Five year old Leslie was dying of leukaemia but as yet the family had been unable to discuss it with the children. In the playroom his seven year old brother drew a picture of himself helping Leslie up the steep hill. He then drew himself walking down the other side alone.

Meet the Child's Need to Cope with Separation and Deprivation (and/or over Stimulation).

TPPs must recognition the central and constant role of families in the development of children. Parents are part of the programme; they are encouraged to play with their child, to bring things from home and to share their concerns about their child. HPS have a depth of understanding in child development enables them to explain to the family their child's reaction to hospitalisation both during the hospital stay and after discharge. HPS provide activities to keep children in touch with their home (telephones, playdough, family play, dolls houses). Siblings are actively encouraged to participate in the programme. Research suggests psychological upset in many of the siblings of children with chronic illness (Siemon, 1986; Menke, 1987; Ferari, 1987; Carr-Gregg and White, 1987).

Five year old Lisa was in the family play corner waiting while her brother had his treatment. She looked sad and anxious. The HPS said "I wonder why Mummy and Daddy are taking so long ". "Because they love Luke the most," said Lisa.

The experience of being hospitalised inhibits the child's ability to play. Their treatment and illness often restricts their mobility. Parents often misinterpret their withdrawal for the lack of desire to play. Stimulus deprivation can be a reality for the young patient. Equally the young child can be overstimulated by the hospital experience. Young children will meet more than 100 new people on their first day of admission to hospital (Grant, 1983). Play is important because it is something familiar in this strange environment, it helps maintain the relationships with the family and it is a way to begin relating to hospital staff that are caring for the child.

Theoretical and Conceptual Framework of a Therapeutic Hospital Play Programme

From this discussion of the aims of TPPs and their application it is possible to discuss the conceptual framework on which TPP are based. The programme is based on the premise that TPP can reduce the stress experienced by hospitalised children and their families and enhance their abilities to cope effectively and gain from potentially stressful situations. The conceptual framework for the TPP developed at Auckland Children's Hospital is based on theoretical and research literature related to child development, stress information processing and supportive relationships.

Developmental theory provides the underlying conceptual framework in the writing of the aims and their implementation. Theory and research show that the child's developmental stage affects their response to hospitalization and hospitalisation can effect the child's development. The programme relies heavily on Piaget's theory of cognitive development and Erikson's theory of personality development.

The second major premise is that it is desirable for children experiencing anxiety to cope with these feelings (coping model) rather than displaying fearlessness, withdrawal and other avoidant behaviour. Psychological stress has two aspects; the event or stimulus that causes the stress and the individuals response to the stress. The programme aims help with the response aspect of stress by listening to and working to correct misconception, by actively teaching coping strategies and giving the opportunity to increase a child's understanding of their treatment and illness. The event can often be made less stressful to the child by increasing the understanding of staff of the psycho-social needs of the child and encouraging changes in the environment and case management that reflect those needs. Children who have repeated experiences of ineffective coping may develop the maladaptive syndrome of "learned helplessness" (Seligman, 1975). Effective coping can be linked with the concepts of "mastery" (Freud, 1966) or "effectance" (Bandura, 1977). Children who experience a sense of mastery and competence in hospital theoretically will be able to generalise these feelings of competence to future stressful events. Rotter's concept of locus of control (1954) is helpful in assessing a child's belief in her competence in coping with the stress of hospitalisation.

The third major premise is that children can process information when in a stressful situation and that play has a crucial role in the processing of this information. Play allows children to process information at their own pace, to create and play through, repeatedly, situations that may be of particular concern. Observation of children at play allows for the monitoring of children's understanding, any misconceptions held and areas that the child may be avoiding.

Underlying and essential to the effectiveness of the above is the role of a supportive relationship between the HPS and the child and family. A supportive relationship is characterized by advocacy, mutual trust and open two way communication, a focus on coping and competence, a developmental perspective and a family centred approach.

The components of the conceptual framework are interactive. The processing of information depends on the child feeling competent and masterful; feelings of competence can result from successfully coping with the stress of hospitalisation. Coping strategies depend on having some knowledge and understanding of what is happening. Play and the supportive relationship with the HPS are the key and underlying features of this individualized, interactive approach to the provision of a therapeutic play programme for hospitalised children.

Bibliography

Bandura, A. (1977) Social Learning Theory
Englewood Cliffs, NJ: Prentice Hall

Beuf, A. (1989) Biting off the Bracelet
Philadelphia: University of Pennsylvannia
Press.

Carr-Greg M. & White L.Siblings of Paediatric Cancer Patients:
A Population at Risk
Medical and Paediatric Oncology 15:62-68
1987.

Clatworthy, S. Therapeutic Play: Effects on
Hospitalised Children
Childrens Health Care: Journal of the
Childrens Health. Spring 1981, Vol.9,
No.4.

Ferrari, M. The Diabetic Child and Well Sibling:
Risks to the Well Child's Self-Concept
Children health Care, Winter 1987, Vol.
15, No 3.

Freud, A. (1966) The Ego and the Mechanisms of Defense
New York: International Universities
Press.

Gaynard, L., Wolfer, J., Goldberger, J., Thompson, R., Redbum, L., Laidley, L., (1990)Psychosocial Care Of Children In
Hospital: A Clinical Practice Manual.

Grant, V. J. Pedestrian Traffic in a Paediatric Ward
NZ Medical Journal. 1983. Vol 96.

McCue, K. Medical Play: An Expanded Perspective
Childrens Health Care. Winter 1988, Vol.
16, No 3.

McKinlay, R. (1979) The Care of Children in New Zealand
Hospitals. National Child Health Research
Foundation

McKinlay, R. (1983) Play For Children in Hospital: Luxury or Necessity. Paper presented at the Third New Zealand Early Childhood Conference.

Matthews, B. (1987) Aims of a Therapeutic Play Programme (unpublished).

Menke, E. M. The Impact of a Child's Chronic Illness on School-Aged Siblings, Childrens Health Care. Winter, 1987, Vol. 15, No 3.

Rotter, J.B. Social Learning and Clinical Psychology Englewood Cliffs, NJ: Prentice-Hall, 1954

Siaw, S.N., Stephens, L.R., & Holmes, S.S., Knowledge About Medical Instruments and Reported Anxiety in Pediatric Surgery Patients. Children's Health Care, Winter 1986, Vol. 14, No 3.

Thompson, R.H. Where We Stand: Twenty Years of Research On Pediatric Hospitalization and Health Care, Childrens Health Care. Spring, 1986, Vol. 14, No 4.